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CONTENTS

PERFORATING DUODENAL ULCER, WITH REFERENCE TO PAIN IN LEFT SHOULDER AS A SYMPTOM, ...	A. A. MATTHEWS, M.D., ...	159
MEDICAL GYNECOLOGY, ...	WM. T. WATSON, M.D., ...	169
BRIGHT'S DISEASE TREATED WITH POTASSIUM NITRATE, ...	JOHN VASSALLI, M.D., ...	177
RECORD OF A FRENCH CASE OF FEMININE SEXUAL INVERSION, ...	DOUGLAS C. MCMURTRIE, ...	179
EDITORIAL, ...		182
Male Sterility, ...		
MEDICAL ITEMS, ...		184

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Antihistogistine (Denver Chem. Co.)..	xi	Gundry Home, Richard.....	xxx	Sharp & Dohme.....	xvii
Arlington Rest Sanitarium.....	xxii	Katharmon Chemical Co.....	iii	Smith, G. T., Dr.....	lii
Armour & Co.....	Front cover	Kress & Owen Co.....	xiii	Smith, L. C., & Bros. Typewriter Co.	xiv
Baker, John C., Co.....	vii	Lambert Pharmacal Co.....	i	Smith, Martin H., Co.....	xvi, xxvii
Battle & Co.....	x	Lilly, Eli, & Co.....	vi	Storm, Katharine L.....	xxxi
Betz, Frank S., Co.....	vii	Med. Society Meetings.....	iv	Sultan Drug Co.....	xxi
Bovinine Co.....	2d cover	Mellin's Food Co.....	xx	Thomas & Thompson Co.....	xxx
Breitenbach, M. J., Co.....	xv	Mosby, C. V., Book Co.....	x	Towns Hospital, Chas. B.....	viii
Chalfonte Hotel.....	xix	Ogden, A. G., Co.....	vi	Underwood Typewriter Co.....	ix
Crittenton, C. N., Co.....	vii	Parke, Davis & Co.....	3d cover	University of Maryland.....	xxxi
Daniel, John B.....	xii	Peacock Chemical Co.....	xv	Washington Sanitarium.....	xx
Fairchild Bros. & Foster.....	v	Phillips, C. H., Chemical Co.....	xvii	Willms, Chas., Surgical Inst. Co.....	viii
Fellows Medical Mfg. Co.....	xviii	Pollack's.....	viii		
Fleet-McGinley Co.....	xxxi	Purdue Frederick Co.....	2d cover		
Foley & Co.....	xxii	Quayle, C. H., M.D.....	ii		
Fougera, E., & Co.....	4th cover	Radium Chemical Co.....	xxiii		
Fritzsche Bros.....	xvi	Radium Limited, U. S. A.....	xxiv		
Galen Hall, Atlantic City.....	4th cover	Reed & Carnrick.....	xix		
Galen Hall, Wernersville, Pa.....	xvi	Relay Sanitarium.....	xxx		
Gardiner Dairy.....	xxii	River Crest.....	xxx		
Gordshell Chemical Co.....	vii	Robins, A. H.....	xxxi		

LOCAL DIRECTORY

Chattolance Spring Water.....	xxvi
Fowler Towel Service.....	xxvi
Henneman.....	xxvi
National Bank of Baltimore.....	xxvi
Pikesville Dairy Co.....	xxvi

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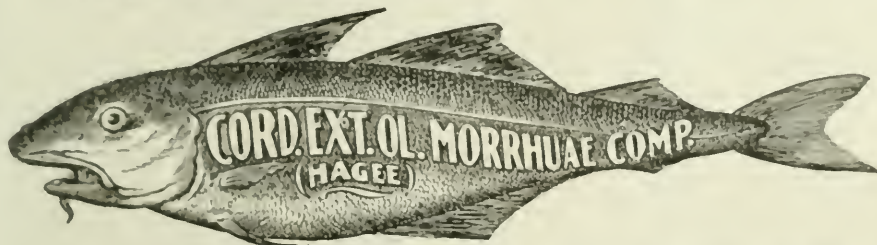
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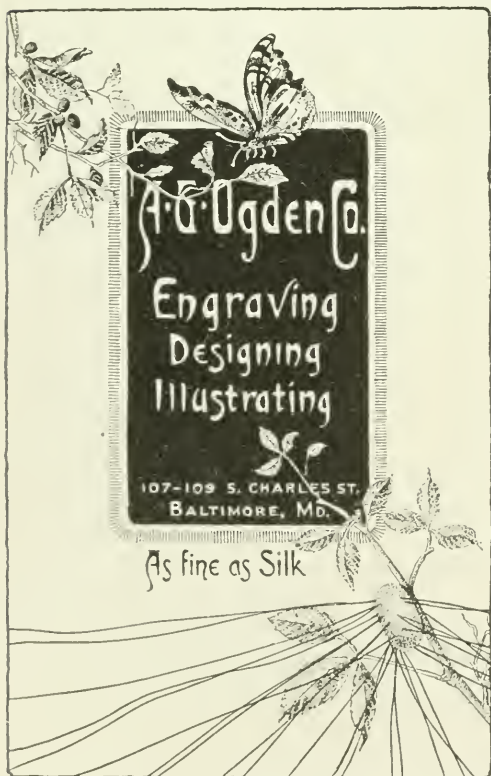
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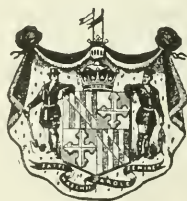
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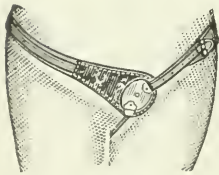
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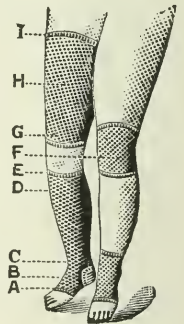
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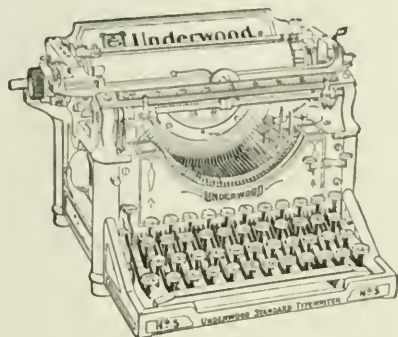
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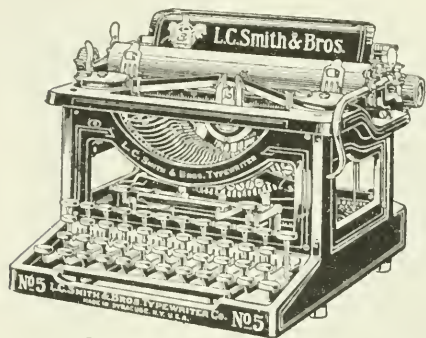
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PERFORATING DUODENAL ULCER, WITH REFERENCE TO PAIN IN LEFT SHOULDER AS A SYMPTOM.*

By A. A. MATTHEWS, M.D.

RECENTLY there has been much written in the magazines regarding this condition; formerly it was the gastric ulcer, but of late the limelight has been directed to the duodenum.

There is one thing which has impressed me very forcibly in four of the cases which I am reporting, and of which I have not seen reference in any literature at my command, and it seems to me worthy calling attention to, and I would be glad to hear from you gentlemen who have dealt with such cases, especially in reference to this symptom. That is a referred pain to the left shoulder, not in the upper left side or the back or upper chest, which I admit is often seen in ulcers on posterior surface of stomach and other conditions, but the shoulder proper. I do not know why such should be the case and why it has been a prominent symptom in my small collection of cases.

In cases 3, 4, 5 and 6, as you will note by the histories, this was a prominent symptom, especially so in Case 4, whose chief pain seemed to be centered there, and the first thing he complained to me about when I saw him was the pain in his left shoulder.

I am inclined to think this symptom is present very often, but we have had our attention centered on the belly, and simply accept it as a referred pain to the chest, which is common in upper belly conditions, and have not suspected or inquired in regards to it.

It would hardly be a coincidence to find this symptom in four straight running cases. Such has been the case in my small series.

*Read before the Spokane County Medical Society, December 13, 1913.

I will run over briefly the subject of perforating duodenal ulcer before going into the histories.

These perforations still often escape recognition and are mistaken for other lesions, and consequently result in the delay of proper treatment and often terminate fatally, notwithstanding the advances and progress that has been made in abdominal diagnosis of today.

Practically one can always elicit a history of previous gastric disturbance varying in intensity from severe symptoms to mild dyspeptic disorders. There are few instances where there have been no premonitory symptoms at all, and the perforation to occur without the slightest warning, but these cases must be regarded as extremely unusual.

The objective symptoms are most important, the character of the respiratory movement, the preponderance of thoracic over abdominal breathing.

The muscular rigidity is always constant and a most valuable objective sign. The belly at first is not distended, but retracted, the muscles ever tense, never relaxing for one moment, which is not so marked in other pathological lesions in the belly, excluding possibly gastric perforation.

When these perforations occur the pain is of the most severe, lacerating character and borne with great difficulty by the individual. If standing, reaching up or moving about the individual will often drop as though shot in agonizing pain, which is aggravated by motion, and even by breathing. So severe has it been that Moynihan reported one case of death due to the violent onset of the pain. The patient is usually prostrated, pale and faint, his eyes set with an expression of terror. The pain is usually epigastric at first, but may vary later according to the location of the exudate and spread of the peritonitis.

Vomiting is possibly the next most common symptom, being present in about two-thirds of all cases. This symptom becomes more prominent as the peritonitis advances. I do not regard this symptom of any special diagnostic value, for practically in all acute abdominal conditions we have vomiting, especially if the stomach contains anything. Blood in the vomit in any quantity in these cases is a rarity.

Shock is a most over-rated symptom, and if there is an immediate shock it is not of much duration and should not be a contra-indication to operation. Van Hook and Kanaval, in Keen's Surgery, say it is always well to let the initial shock pass by and allow the patient to gain some strength before opening the abdomen. They further state that in a short while this usually passes away.

I think this a mistake, for as soon as the diagnosis is made the operation should be performed, and it cannot be done too soon, even though there is a question as to the exact diagnosis. If a perforation is suspected, the work should begin at once.

The disappearance of liver dullness by many is considered an unreliable symptom, and if present, is a late one; and, too, I think too much stress is placed upon dullness in the flanks, it being, in my opinion, rather uncertain, unless considerable time has elapsed for fluid to collect, and it does not help us a great deal in making a differential diagnosis. Dr. Elliot claims he can, by auscultation, elicit very small quantity of fluid located in these regions, and regards this symptom with considerable importance.

I will not go into detail as to differential diagnosis. The most common error is to confound the trouble with acute appendicitis, and this mistake was made in two of the cases I am reporting. There is no grave mistake in making this error, for if there is a question in the mind of the operator he most certainly should lean toward the appendix and make a McBurney incision; and then, if finding the appendix not involved, it serves as a very adequate drainage by passing a tube into the culdesac, for in all of these cases the writer considers it decidedly the safest procedure. And, too, if there is considerable infection, it is well to put in a drainage under the kidneys.

As to the treatment of these ulcers, there seems to be much controversy, some claiming to excise and then suture to be the proper procedure. But I believe most authors who have written on this subject are inclined to simply suture and fortify, if necessary, the area with a piece of omentum.

In the cases which I am reporting this was done and no attempt to excise the ulcer. I do not consider it practical unless located on the anterior surface, and even then unnecessary. When located posteriorly or far around from the front it would make it a very much more formidable operation and increase the danger to our patient.

There have been a number of cases reported when death followed some time after the operation where the suture alone was used, and in all these cases the result was as perfect as could be expected; and one case reported by Mennoch, nine weeks after the operation, at the autopsy no trace of the ulcer was found.

A much-mooted question among many operators is the advisability of doing a gastro-enterostomy at the time the perforation is sutured, and there are very good arguments for and against.

I believe each case should be an example within itself, as well as the ability of the operator to be considered.

Dr. Deaver is an ardent supporter of this procedure. With a man of his ability and experience, a procedure of this character would often be advisable, while in other hands, the same condition existing, it would be unwise. In none of the cases which I am reporting was this procedure advisable, except possibly one, and that being Case 2. In the future, in the early cases gotten a short while after perforation, I believe, there being no contra-indication, I would do a gastro-enterostomy. But these will be selective cases, not the general run.

Dr. Deaver further reports that of cultures taken from the peritoneal fluid of 20 cases, only 6 showed any growth, and he believes the irritation is a chemical one rather than a bacterial one at first. Of course, there are conditions where the pylorus is much constricted by infolding of an indurated ulcer, making a gastro-enterostomy essential in some few cases.

The question of drainage in these cases is a very important one. If the McBurney incision has been made, it will act admirably for a drainage tube to pass down through into the pelvis. The patient should be kept in the extreme Fowler position so that the sub-phrenic spaces will drain, it being more difficult to drain these areas than any other part of the peritoneal cavity on account of their being partially surrounded by bony framework. It has been advised to make counter openings through the lower posterior pleural space. I do not consider this a justifiable procedure at first, but, if necessary, may be resorted to later if the extreme Fowler position does not suffice. It was necessary for me to do so in Case 5. A supra-pubic stab wound with a split drainage tube in the pelvis will suffice, and is more satisfactory than any other form of drainage material.

The routine after treatment of these cases has been extreme Fowler position, pelvic drainage, preferably a split tube, which is gradually shortened about an inch a day, beginning about 36-48 hours after the operation, never removing the tube, but simply drawing up and cutting off each day, using a safety pin in tube to keep from losing same in wound. Continuous proctoclysis, usually the Murphy method or some modification.

I wish to state here that I prefer warm tap water to the saline, while up until about 18 months ago I always used the saline; but after reading and seeing some splendid results gotten in nephritic cases by the salt-free diet, and knowing that any amount above $2\frac{1}{2}$ to 3 grams was an excess to an individual in 24 hours, made me think that by throwing in great quantities of normal salt solution, sometimes as much as 18 pints in 24 hours, it was a great tax on the kidneys, and makes one wonder sometimes if we have not hurried on suppression cases over the Great Divide, or possibly been in a mild way partially responsible for the cause. We can never drink salt water. Why should we be forced to do so without tasting? Absolutely nothing by mouth, the free use of the stomach tube every three to four hours if there is persistent vomiting or a tendency to gastric dilatation.

In these cases I never give water by mouth until the patient has gone at least 12 hours without vomiting. After a bowel movement give beef tea, broth or egg albumen in small quantities every two hours, and then gradually increase, then put them on slops.

The bowels should be only moved by enema, never giving medicine by mouth. For the following six months make them follow a rigid diet, eating nothing except that which has been put through a small sieve. This, I believe, will insure them a cure, even though

the gastro-enterostomy was not done at the time of the primary operation.

Another thing that cannot be too strongly emphasized, and that is to avoid the use of morphine in these cases until one is satisfied as to the diagnosis and what procedure is to be taken, for the influence of this drug in these, as all other acute abdominal catastrophes, puts false hope into our patients and their family, and at the same time is very deceiving to the physician, putting off the only procedure that can save life, and incidentally lessening their chance of recovery very materially every hour that they delay.

SUMMARY.

First—Diagnosis is made upon person's history, which is always most important, especially the gastric history.

Second—Onset of violent, uncontrollable pain, first epigastric, later referred to chest and general abdomen.

Third—Muscular rigidity of abdomen, retracted at first and boardlike, later distended and tense, respiration limited to upper chest.

Fourth—Treatment only surgical, suturing the perforation and drainage, gastro-enterostomy in select cases.

Fifth—Pelvic drainage, Fowler position extreme, and continuous proctoclysis.

Case 1—September 18, 1908.—C. H., age 26, occupation a miner. Family and past history negative, except had noticed a little gastric disturbance in his right side high up when he ate in excess, but this was never so severe as to make him restrict his diet in any manner. The discomfort was so slight that he considered it of no moment.

While coming from the mine he was taken with a severe abdominal pain in his upper abdomen and vomited.

The examination revealed temperature $99\frac{1}{2}$, pulse 100; the abdomen was retracted boardlike and extremely sensitive, most of his tenderness being in his right side, extending from the costal border well down toward the pelvis, which made it suspicious of some appendicular trouble. He was operated upon a few hours after the perforation had happened.

An incision was made over the appendix region. The belly was found full of yellow fluid and the appendix not to be the cause of the trouble, although the same was removed. An opening was made through the right rectus muscle high up. A small perforation was found in the pylorus about an inch from the stomach, which was sutured over with two rows of chromic catgut. Drainage was inserted in the pelvis through the appendicular incision.

Patient made an uneventful recovery and was last seen about six months after the operation, and had been perfectly well up until that time. Have not been able to locate him since.

This case was operated upon by my brother and associate, Dr. J. G. Matthews.

Case 2—May 28, 1911.—Was called early in the morning, but being unable to go myself, sent another physician. He sent the patient into the hospital with a diagnosis of acute appendicitis. Immediately upon arriving I saw him, a man of 38 years, occupation a teamster, being powerfully built and muscular. His family and past history of no value.

Gives history of having had for some time a gnawing and burning in his stomach, but it was never so severe as to hinder him from attending his usual work. He never restricted himself as to his diet. This annoyance was of such small consequence that he never thought it worth mentioning, but now recalls that he had it off and on for quite a while between meals.

After eating his breakfast went out to hitch his team, and while doing so he was taken with a violent, lancinating pain through his upper abdomen. The pain was so great that he dropped to the ground and remained there until his neighbors carried him into the house, at which time they telephoned for me. He vomited two or three times but no blood. When he arrived at the hospital I found him in great pain, although not as severe as it had been at first, he having had a quarter of a grain of morphine hypodermically. His respiration was shallow and hurried, his abdomen being held tense and boardlike, pulse 80, temperature 98. The physical examination was negative, except that of his abdomen, which was very sensitive, and the point of maximum intensity being in the upper right hypo-gastric region.

Incision was made through the right rectus muscle high up and duodenum at once examined, in which I found a small perforation about the size of a matchstick through the upper anterior surface of the gut. This was sutured with two rows of linen thread, reinforced by a piece of mesentery. A stab wound was made suprapubically and a tube put down into the pelvis, put to bed in extreme Fowler position, with saline by rectum. This patient made an uneventful recovery; left the hospital in about two weeks.

He was operated upon about three hours after the perforation had occurred, and would have been an ideal case for gastro-enterostomy, but at this time I never considered such in these cases, but think if I had it to do over again would do so on account of it being such a favorable case. This patient was perfectly well about one year after the operation. I have not been able to locate him since.

Case 3—December 8, 1912.—N. L., age 36, occupation miller, family and past history negative. About 14 years he noticed occasionally he would have a slight attack of indigestion; also in that time he had four or five attacks in which he would have considerable gastric disturbance and marked constipation, loss of appetite. The discomfort that he felt in his abdomen was in the upper left side. He did not give any distinct history of food distress after eating, but he complained of a soreness which was noticeable especially upon pressure, and that had been almost con-

stant for some time past. On the above date, after eating a heavy dinner and feeling unusually well for the past few days, he was going upstairs about 5 P. M., and just as he got to the top he was taken with a violent pain through his upper abdomen, so severe that he fell to the floor and rolled down the steps. He said the pain was worse in his upper abdomen; a short while later most of his pain seemed to be centered in his left shoulder, and he complained of it a number of times during the examination. The tenderness was excruciating in his belly. He vomited several times.

The next day about 2 P. M. I was called in consultation by Dr. Lee Ganson of Odessa, Wash., about 20 hours from the onset of the attack. At this time found the belly very much distended, his eyes sunken, and in general bad condition. The belly was so sensitive that the examination revealed very little, but it was evident that some grave catastrophe had occurred in his belly, and was most probably a perforated ulcer.

It was with difficulty that I was able to persuade him to have anything done, but by influence being brought to bear by friends and relatives he consented to have the operation.

The incision was made through the right rectus muscle. The belly contained considerable quantity of muddy fluid, and there was found a perforation at the beginning of the pylorus, anterior surface, which was sutured with two rows of linen thread and fortified with a piece of omentum. A stab wound was made suprapubically, a tube inserted into the pelvis for drainage, there being no attempt to swab out the belly. Patient was placed in bed in the Fowler position with continuous proctoclysis. He did unusually well for the first few days, but eventually developed an accumulation of fluid in his chest, which was aspirated on two occasions, but reoccurred, and eventually became purulent, which made it necessary to resect a rib and drain. From this on he made a slow but perfect recovery, and is today perfectly well, and has had no further gastric trouble.

Case 4—May 21, 1913.—McC., age 40, occupation electric engineer. Father died of dropsy, otherwise family history negative. Past history of no consequence. Claims to have always been a heavy eater and never had any gastric disturbance until 3 or 4 years ago, then occasionally coffee which he would take for breakfast would give him some discomfort, but not at any other meal did he notice this; also recently he has noticed that if he ate salads and such food late at night it would give him considerable gastric disturbance. About two weeks ago he began to have indigestion and some pain in his upper chest. He said the food would lodge in his stomach and remain there like a ball. Usually when he awakened in the morning he felt pretty well, but a couple of hours after eating breakfast he would notice there was a gnawing distress in his stomach, and occasionally he would vomit, and recently has had a feeling of discomfort in his upper chest. Two days ago

he went out to his country home, and while there he felt rather uncomfortable in the upper abdomen, and came home in his machine. Upon arriving he was unable to get into the house, the family being away. He was then taken with a violent pain through his upper abdomen, but managed to get into the next-door neighbor's, where he had his family and a doctor called.

He was then transferred to his home. Had vomited a number of times. I was called in consultation about 40 hours from the onset of the acute trouble by Dr. E. L. Kimball of Spokane, who also assisted me in the work. At that time the patient's belly was very much distended, pulse 102, temperature 98. He vomited persistently, and had been hiccupping for the previous 36 hours. The first thing that he complained to me about was the severe pain in his left shoulder, and this he had been complaining of steadily from the onset of his trouble. The point of most sensitiveness was in the right upper epigastric region. He was bathed in a clammy perspiration, and was rather sluggish in responding to questions. His respiration was shallow and jerky, belly distended and tense; his skin and conjunctiva had a yellowish tinge, which made me suspicious of some obstructive conditions of the bile ducts, and possibly a ruptured gall bladder. An unfavorable prognosis was given. I had him transferred to St. Luke's Hospital, where a right rectus incision was made. The belly was full of purulent watery material. Perforation was found on the posterior surface, well down on the first portion of the duodenum. This patient had a very stormy siege for several days, then began to convalesce. After about 10 days began an irregular temperature, when eventually we located a pocket of pus down in the right subphrenic space, which was drained. From this on he made an uneventful recovery and is well and strong today.

Case 5—July 24, 1913.—C. A. M., male, age 22, occupation a surveyor. Family and past history negative up until one year ago, when he began to be bothered with some stomach trouble, feeling of distress in his abdomen, which would come on when his stomach was empty, and would be relieved by the taking of food. The discomfort was mostly about 4 o'clock in the afternoon. He would often lie on the bed before his evening meal on his back, which seemed to give him some comfort.

This discomfort which he has had for the past year has never been so severe as to keep him from his work, nor has he restricted himself as to his diet. He knew some foods were more distressing to him than others. It was a common thing for him to have a certain amount of discomfort a couple of hours after eating, which he noticed was relieved for a short while by the drinking of water or taking some kind of food.

On the 23d of July he did not eat anything during the day. That evening when he was getting ready for his supper in reaching up he was taken with a violent stabbing pain through his upper abdomen. At that time the pain seemed to be most intense on the

right side high up, but later he complained of considerable pain referred to his left shoulder, and this was most marked about an hour after the perforation. He claimed that the pain in his left shoulder seemed to be worse than that in his belly, but on motion or any pressure the pain was excruciating in his belly. He was operated upon about 15 hours after the perforation. A McBurney incision was made over the appendix, which was found not to be the cause. The belly contained a quantity of cloudy fluid. An incision was then made in the right upper belly. A perforation was found in the first part of the duodenum on the upper surface. The same was sutured with two rows of linen, belly drained through appendicular incision by a split tube into the pelvis.

Patient made an uneventful recovery and is now perfectly well, weighs more than he ever did, and is working every day.

This case was operated upon by my brother and associate, Dr. J. G. Matthews.

Case 6—November 9, 1913.—Mrs. W. O., age 34. Had one uncle on father's side die with tuberculosis, also one aunt on mother's side, otherwise family history negative. Had measles, mumps and chickenpox when a child; began to menstruate when 14 years of age, regular, of the six-weeks type, with very little discomfort; has had five children and two miscarriages; was badly torn with the first child, and had what she called bed fever when the second was born; was ill about six weeks.

About 12 years ago was operated upon for perineal teares and retro-displacement of the uterus, and following this operation she claims to have had considerable gastric disturbance, which lasted off and on for three years. This discomfort would begin about an hour after eating. There were certain foods that she avoided, for they gave her considerable discomfort. Raw apples was one thing that always gave her distress.

This condition gradually improved and she thought herself well, but five years ago she had an acute attack with her stomach, and was very miserable for three months following. Any foods would give her discomfort, and she had a referred pain in the anterior chest about midway of the sternum, but during these three months her stomach had a burning sensation the whole time when it was empty. The taking of food relieved it. Following this attack she was pretty well up until last June, save eructation of gas. At that time she had a very similar attack to what she had five years previous, but it only lasted a short while. About six weeks ago her stomach began to give her distress, and this discomfort was most marked about an hour to half hour after eating. She found that taking food in small quantities would give her relief.

This A. M., while still in bed, about 6 o'clock, she was stretching, and was suddenly seized with a violent epigastric pain which was most distressing. The severeness of the pain lasted for about half an hour and then became very much less severe for 15 minutes, and she thought it would pass away, but was seized again

with a similar pain, which continued. She vomited, but no blood. Her family physician was called, Dr. J. W. Sherfey, of Wash-tucna, Wash., who referred the case to me. It was necessary for him to give her several doses of morphine, and eventually resorted to the use of a little chloroform at frequent intervals to relieve her pain, which seemed to be uncontrollable otherwise.

The pain was first in the upper abdomen; later complained of it being in the anterior chest and between the shoulder blades. About one hour after the perforation she had a referred pain to both shoulders. She expressed it as a drawing pain and of considerable severeness. In questioning her as to the location of this pain she said it seemed to be in the joint and on top of the shoulder.

In making the physical examination about 16 hours after the onset of her trouble she was then under the influence of an opiate. From the history I had made my diagnosis of a duodenal perforation, but upon examining her, to my surprise, her belly was rather lax, a soft distension, and at that time not suffering any acute pain, her point of maximum tenderness being in the upper right epigastric region and extended down over the appendix. The left side of the belly on pressure was not so sensitive, and the pain was referred to the right side upon pressure. Her pulse was 104, temperature 98.6. I advised an immediate operation, but now I was not absolutely certain that it was perforation, although the history was quite typical.

She refused to have anything done, was put to bed until the next morning, at which time her condition was but little changed from the night before. She had had some pain, but it was not of a severe character. Her belly was a little more distended, pulse 100, temperature 99.6, but she consented to have the operation.

An incision was made through the right rectus muscle, and upon opening the abdomen found it full of muddy fluid and considerable amount of organized lymph in the neighborhood of the pylorus and gall-bladder, and upon examining the pylorus I overlooked the perforation; then examined the gall-bladder, and finding no trouble there went back to the pylorus and found a very small perforation on the anterior surface of the first portion of the gut not larger than a knitting needle, and at that time not leaking; it seemed to have been plugged with a piece of lymph. Around the ulcer it was much indurated for an area about the size of a dollar, which made it difficult in placing my sutures, for the gut was quite friable. I managed to bury the perforation under two rows of linen suture and fortified the area with a piece of mesentery, made a stab wound suprapubically and inserted split rubber tube for drainage.

The drainage was very profuse the first 12 hours, making it necessary to change the dressing many times.

This patient made an uneventful recovery and is today as well as could be expected in such short time since the operation.

MEDICAL GYNECOLOGY.*

WM. T. WATSON, M.D.

The general practitioner and the specialist are both here to stay, the work of the one supplementing that of the other, each doing for the sick what the other can not.

In reviewing my work as a general practitioner, I find that I attend from 90 to 95 per cent. of the ailments which occur in the families under my care, referring to specialists the other 5 to 10 per cent. I strive to make the welfare of the patient the only point in deciding whether to treat or to refer.

I have selected from my records for presentation tonight two classes of gynecological cases which I have treated in recent years. I am sure that it will be readily conceded that most of these cases properly remained in the hands of the general practitioner. It is quite possible that some of them might have fared better at the hands of the specialist. Upon this point I will welcome frank criticism.

I.

SOME WONDERS OF THE PESSARY.

Some years ago, under anesthesia, I replaced a uterus and used a pessary. Two months later my patient demanded that I perform an abortion upon the ground that had I told her of her increased liability to pregnancy she would have kept her ailments. I did not perform an abortion, neither did I get my fee for replacing the uterus. She changed physicians and never had the baby. I can recollect a number of cases where pregnancy rapidly followed a replacement, and am sure that there are many people who owe their existence to a pessary.

STOMACH SYMPTOMS OF REFLEX ORIGIN.

Aside from its role in increasing the population, the pessary has many other achievements to its credit.

Its agency in the cure of what appears to be stomach trouble is, I think, illustrated by the following cases:

Mrs. J. B. For two years had suffered with attacks of nausea, vomiting and faintness. Had lost much in weight. Had given up all social life because she so frequently became suddenly and alarmingly ill. There was no complaint of pelvic discomfort and her country physician made no examination. He explained her condition on the theory of frequent conceptions followed by frequent early abortions. The patient and her husband came to see that this theory failed to harmonize with all the facts in the case, so she was brought to the city.

Outside of her emaciation the only demonstrable lesion was a badly retroverted uterus. This was replaced and a pessary introduced.

*Read before the Baltimore City Medical Society, February 29, 1914.

From that hour she had no nausea. She steadily gained in weight and strength for one year, when she became pregnant. When three months pregnant the pessary was finally removed.

Here the pessary certainly cured the stomach symptoms and was almost as certainly responsible for the existence of a much-desired girl baby, as eleven years had elapsed since the birth of her last child.

Mrs. R. N. C. Aged 22 years. Married three years. One child 18 months. One miscarriage six months ago. Complained of weakness, loss of weight, frequent nausea, soreness in epigastric region not associated with time of eating, occasional faint spells, and almost constant pain in lumbar region.

A general examination was negative with three exceptions: Hemoglobin 80 per cent., abdomen generally hyperesthetic, uterus retroverted. Test breakfast showed some hyperacidity.

I replaced the uterus and used a pessary. She protested against this because many previous attempts had been futile and she had no discomfort from the misplacement. A properly modified pessary proved successful. I also prescribed a diet.

The patient at once lost her nausea and faint spells and the backache improved. Her weight went from 113 to 130 pounds. My diet list was soon forgotten. On the four or five occasions in the past two and a half years on which nausea has returned it was always associated with a lateral displacement and disappeared promptly on readjusting the pessary. The stomach symptoms were doubtless of reflex origin.

Miss H. For several months menstruation was increasingly painful. Then she had a menstrual period accompanied by severe pain and vomiting. The vomiting continued for seven days after the cessation of the menses, and for this I was consulted. I found the uterus completely retroverted. Its replacement with the use of a pessary stopped the vomiting at once and the next menstrual period was painless. The pessary soon caused ulceration and was removed. There was no return of retroversion or of symptoms.

MENTAL DEPRESSION OF REFLEX ORIGIN.

The next three cases illustrate the agency of the pessary in the relief of distressing mental states.

Mrs. A. N. Had a complete prolapse of uterus and bladder, associated with malaise, nervousness and great mental depression. Life was not worth living. The use of a Zwank pessary completely changed the picture and she was practically well again. Tiring of the care of this instrument she decided to undergo an operation. For some months this was successful, and then the bladder became prolapsed, accompanied by the same mental and nervous symptoms, accentuated by the knowledge that the operation had been a failure and the fear that further relief was not to be had. The Zwank pessary could not be used. An inflatable pear-shaped pessary was introduced, and again the picture changed. This has been worn for a year and the patient is in robust health and fine spirits.

Mrs. B. Since birth of her last child, three years ago, had been steadily losing in vigor. Had to give up housekeeping and go to boarding. Was not equal to caring for her two children and one room in a boarding-house. Felt as though her brain was in a vise and as though she would go mad. She had no pelvic discomfort.

A general examination was negative except that she was thin, her hemoglobin 70 per cent., her uterus retroverted and cervix lacerated.

The uterus was replaced with considerable difficulty and a pessary inserted.

A week later her husband said I had worked a miracle—that his children were being looked after and he could get his buttons sewed on. The patient said that her brain had been immediately relieved from compression, and melancholy had given way to cheerfulness. This condition continues after the lapse of four months.

Mrs. T. S. N. Seen seven years ago at age of 54 years. Had a complete tear of perineum with eversion of rectal mucous membrane, dating back many years. Had also a complete prolapse of uterus and bladder. Could walk but a few squares. Urination every few minutes. Was nervous and melancholy and at times almost frantic. After replacement and the use of a Zwank pessary the frequent urination ceased and patient could go down town on long shopping trips. Her mental state underwent just as complete a change for the better. Is still wearing the pessary with the same satisfaction. This patient has diabetes. Because of this and her complete relief I have not urged operation.

II.

DYSpareunia AND ALLIED TROUBLES.

One of my patients once lamented that she could not have gone on courting all her days; courtship had been so sweet and married life so bitter. She was suffering from dyspareunia.

I have met with a good many cases in my practice where marriage, instead of being a proper climax to the anticipation of lovers, has proven to be a rude and disappointing anti-climax because of pain in coitus. While the pain is endured by the wife, the husband cannot derive pleasure while causing suffering to another.

In the last three or four years I have seen a greater proportion of such cases than formerly, probably because I have seen the necessity of more frequently asking my patients about such matters.

The causes and treatment of painful and difficult intercourse are various, as will be seen by the different groups of cases which follow:

HYMENAL OBSTRUCTION.

Mrs. C. D. Aged 23 years. Seen in December, 1913. Married in March, 1912. For one month coitus impossible. Then with much pain and hemorrhage it was effected. For four months

there was no pain and no pleasure—then a month of normal sexual gratification, when, in the words of the patient, "married life seemed worth while." Became pregnant, and was uncomfortable ever after, and intercourse ceased to give pleasure. Now in fifth month of pregnancy.

Mrs. B. A. Aged 22 years. Seen in January, 1914. Married two years. Pregnant five months. Coitus not accomplished for *one year*, when, under ether anesthesia, her physician trimmed away a thick, tough hymen. Five weeks later there was intercourse without pain. Patient has never experienced the slightest pleasure, but keeps this a secret from her husband.

Mrs. S. K. Seen in October, 1913. Married one year. Pregnant four months. Two months elapsed before intercourse was effected. Trouble seemed to be due to tenderness and spasm. After it was effected an obstruction seemed to be met with in the vagina which gave rise to pain in lower abdomen. Intercourse rarely indulged in and never a source of pleasure.

Examination: Hymen had never ruptured; had stretched without breaking. Uterus sagging backwards was squarely across the vagina. Pressure upon it gave the pain complained of during coitus.

The hymen was largely removed with tonsil punch. One week later the vaginal orifice still tender and intercourse had not been attempted. Patient hoped it would never occur again, as it had become repugnant to her.

Seen four days ago. Now eight months pregnant. Had not permitted intercourse for four months.

OBSTRUCTION DUE TO FAULTY REPAIR OF PERINEUM AFTER CHILDBIRTH.

Mrs. G. R. Six years ago, following the repair of an extensive perineal laceration after childbirth, there was several months when intercourse was impossible. Under an anesthetic I stretched the vaginal orifice. The patient then moved to the country. Recently she reported that the stretching had effected a cure.

Mrs. S. R. Two months after the birth of her baby reported that coitus was impossible. Inspection showed that a thin web of mucous membrane had been misplaced in stitching up the perineum and acted as a barrier. A cure was promptly effected by clipping the membrane antero-posteriorly and the insertion of two catgut sutures.

OBSTRUCTION DUE TO FAULTY REPAIR OF THE PERINEUM BY THE SURGEON.

Mrs. S. L. Tiring of a pessary, was operated on for a retroversion. For about seven years this was successful. During this period she gave birth to two children. Retroversion occurred again in November, 1912, and a second suspension was done in December, 1912. Along with this operation was another for relaxed vaginal outlet. As she was leaving the hospital she was

advised to use a douche. She found difficulty in introducing the nozzle; felt as though she had been closed up entirely. For several months coitus was impossible. After the lapse of fourteen months coitus was possible, but was always painful. Felt as though the trouble was at the entrance. Patient always more amorous than husband. Her mind dwelt upon this changed condition and she was quite depressed.

Examination showed the vaginal outlet to be contracted and quite tender. Under local anesthesia I incised the obstructing tissue, and a cure has resulted.

LACK OF DESIRE AND OF NORMAL SECRETIONS.

Mrs. G. D. Aged 27 years, married three months. Coitus always painful at the beginning and a feeling of being overstretched afterwards. Does not know what sexual desire or gratification means. Her sexual organs seem dead to her except for the sensation of pain on intercourse. On examination nothing abnormal found. The trouble seemed to be a lack of desire and of normal secretions. Artificial lubrication recommended, which was of some benefit. Is now pregnant, and this may rectify the condition.

Mrs. S. G. Aged 30. Married three years. Coitus daily for first year. Now once or twice a week because her general health is impaired. Thinks her husband is large. Coitus at times difficult and painful at the beginning; at other times normal. If husband is under the influence of liquor, coitus is distasteful and quite painful. The difficulty here is apparently due to mental attitude and consequent lack of normal secretions.

MALPOSITION OF VAGINAL ORIFICE.

Mrs. B. *Married three weeks.* Coitus not yet accomplished. On examination hymen was thick, intact and very sensitive. Portions of the hymen were excised with a tonsil punch.

Three months later she reported that intercourse could only be effected by approach from the rear, which was a source of dissatisfaction and humiliation, and coitus had become very repulsive to her.

I now found that when she was on her back the lumbar region was greatly arched and the vaginal orifice close to the table.

At the end of another month conditions were not altered. While she was on my table I told her that I wanted an X-ray made of her spinal column. While this conversation was in progress I noticed that her lumbar region was in contact with the table and the vaginal orifice in normal position. The whole trouble was of nervous origin, mental excitement of any kind causing this peculiar contraction of the back muscles.

When the situation was explained to her the trouble was at an end.

HYPERESTHESIA OR "VAGINISMUS."

Mrs. Z. Consulted me because of an intermittent pain in right inguinal region. On attempting a pelvic examination it developed that although she had been married two years intercourse had not

yet been possible. The abdomen was hyperesthetic and exceedingly ticklish. Vaginal orifice hypersensitive; hymen thick and opening small.

Under cocaine, pieces of the hymen were removed with a tonsil punch.

Two weeks later coitus still impossible.

I then lost track of her for ten months, when I was told that she had become pregnant. Of course this does not necessarily imply that intercourse had actually occurred.

Mrs. C. Has been married 10 years. Is very desirous of offspring. Coitus so painful that it is only attempted about twice a year, and then at her request. Examination is negative except for a condition of hyperesthesia.

WANT OF CORRELATION BETWEEN HUSBAND AND WIFE.

Mrs. E. M. Married three months. Coitus always painful. No trouble in vaginal orifice, but an obstruction higher up. On examination the vagina was found to be unusually short and the uterus lying far back. A pessary was introduced and the husband told of the condition. With proper consideration on the part of the husband no further pain was experienced.

Mrs. W. K. S. Aged 48 years. Menstruation ceased at 41 years. Married twice, the first time at the age of 18; the second time at the age of 34. With first husband coitus never painful, but was always practiced from the rear because more agreeable. With second husband coitus in normal position, but always with some difficulty and with very little pleasure. Second husband larger than the first. For the past year coitus almost impossible. Examination shows an atrophied condition due to age. Patient told that no relief is to be expected.

Mrs. T. H. S. Aged 55 years. Married for many years to first husband. Coitus never painful. Patient always more amorous than husband. Seventeen years ago, at the age of 38, married her present husband, who is 13 years younger than herself. Second husband larger than first. Intercourse always painful, but not to the entire exclusion of pleasure. Eight or more years ago, at the age of 43, underwent an abdominal operation, after which menstruation abruptly ceased. Coitus soon became more difficult, and two years ago impossible. An examination showed a condition of atrophy, due to age and operation, which precludes sexual relations.

The patient is in a melancholy state; thinks that her husband must be seeking gratification elsewhere, although unaware of any act of infidelity. I was asked to interrogate her husband on this point, but concluded that nothing was to be gained by it. It was a case where ignorance should have been bliss, but wasn't. Nothing short of the castration of her husband would apparently satisfy her.

Mrs. H. Married six weeks. Has lost weight, is nervous, depressed and disgusted with married life. Ever since marriage had

pain in left inguinal region and an uncomfortable feeling in the pelvis.

Coitus exceedingly painful, and not accomplished until five days after marriage. It has occurred almost daily since, the pain increasing instead of diminishing as prophesied by her husband (a widower). Is completely exhausted after the act. The pain is at the vaginal orifice.

On examination the hymen was found to be ruptured and the vaginal orifice exceedingly tender. No pronounced vaginismus. Uterus normal; no tenderness in sides. Husband found to be unusually large.

Less frequent indulgence and the use of a suppository containing one-half grain cocaine and one-eighth grain morphia advised.

A month later the patient was in good health and spirits. Coitus better tolerated, but never a source of pleasure.

Mrs. R. C. Aged 23 years. Married in October, 1913. Seen by me three months later (January, 1914). Coitus always painful. An obstruction seemed to be met with. I had attended the husband prior to his marriage and knew him to be abnormally large. Examination of wife showed vagina small and uterus low down and in the way. A pessary only made matters worse. I told her that if she could have a child that her discomfort would probably cease.

MALPOSITION OF THE UTERUS.

Mrs. T. I have elsewhere related a case where a bride of 24 hours was thought to have appendicitis by a prominent physician in another city and an operation urged upon her. The wedding journey had to be abandoned and she returned to Baltimore. I found the uterus upside down and very tender. After replacement and the use of a pessary all discomfort ceased.

Mrs. B. M. Married three and a half months; pregnant two months. Five days elapsed before coitus accomplished. Since then very little trouble until recently, when intercourse is difficult at the beginning but not later, though husband complains of meeting an obstruction. Asks me to advise husband to abstain during the remainder of pregnancy.

On examination the pregnant uterus is low down, the cervix lying completely across the vagina and resting upon the sacrum.

A pessary was introduced.

At a subsequent visit all discomfort to patient and husband gone, but patient was averse to intercourse. It always seemed as though she were committing a sin. Thought she had remained a maid so long that her mind could not change from the normal attitude of the maid to that of the matron.

Abstinence was not advised.

Mrs. D. L. Aged 25 years. Married seven years. Baby five years old. Since birth of baby coitus always painful, never a

pleasure, now a source of dread, and rarely indulged in. It is followed by aching for next 24 hours. An obstruction seems to be met with.

Examination: Uterus completely retroverted; vagina short. Uterus replaced and pessary introduced.

Five months later reported that coitus was never painful.

Two months later became pregnant, and later on a seven-months' tubal pregnancy removed at operation by Dr. Miller of Washington. (Patient's statement.)

Mrs. L. Married 11 years. No children. Coitus painful when tired out from housework; at other times not. The uterus was small, sharply anteфлекed and low down, the cervix coming within an inch of the vaginal orifice. A pessary relieved her of all pelvic discomfort and coitus occurred without the slightest pain.

Mrs. M. L. R. Married two years. Never pregnant but desirous of offspring. Very nervous and tearful. Coitus always painful, makes her nervous, and was usually followed by a prolonged crying spell. Feels as though some obstruction is met with in the vagina, and pressure upon this gives pain.

Examination showed the uterus to lie far back, the cervix resting upon the sacrum. Pressure upward caused sharp pain. The vagina was capacious. A pessary was introduced, which changed the position of the uterus.

Three and one-half months later patient reported that since introduction of the pessary coitus was always painless, and for the first time she knew what sexual gratification meant. She was then six weeks pregnant.

CONCLUSIONS.

In thinking over some of the cases where after some painful experiences the patients have developed a strong repugnance to the sexual act, it occurred to me that had a physician early been called and the trouble relieved, the mental attitude might have remained normal.

I find support of this view in this paragraph from Kelly's Medical Gynecology regarding ineffectual attempts at intercourse: "The *libido sexualis* which normally attends and renders transitory the natural pain of the first cohabitation, disappears, and an attitude of anxious expectancy takes its place, which, in time, is converted into apprehension and abhorrence, so that instead of gratification the wife feels disgust, and instead of pleasure, pain."

If this be so, it is an argument for early diagnosis, which can only be obtained in many cases by proper questioning by the family physician when trouble is suspected.

BRIGHT'S DISEASE TREATED WITH POTASSIUM NITRATE.

By John Vassalli, M.D.,

Baltimore, Md.

I HAVE treated over thirty cases of Bright's disease in the last year successfully with potassium nitrate. I will give a short history of eleven:

First.—F. E., barber, 51; drinks occasionally a glass of beer. Urine analysis: December 13, albumen, blood, granular, hyaline and waxy casts; December 16, albumen, blood, no casts; December 25, albumen; December 31, trace of albumen. The next three months sometimes normal, sometimes a trace of albumen. April, urine normal.

In the following four years the urine was normal. Patient died from tuberculosis not long ago.

Second.—K. S., musician, 63; potator. October 18, albumen, uric acid, blood, hyaline casts, pus; October 22, trace of albumen, uric acid, no blood, no casts, no pus; October 27, uric acid, no albumen, no blood, no casts.

Third.—M. W., baker, 48; drinks moderately beer. September 19, albumen, uric acid, blood, hyaline and waxy casts; September 25, albumen, uric acid, blood, casts; October 5, no casts, no blood, uric acid, trace of albumen.

Fourth.—Wm. B., car conductor, 51; drinks moderately beer. January 17, albumen, blood, hyaline and waxy casts; January 20, albumen, no casts, no blood. Patient did not return for treatment.

Fifth.—C. S., shoemaker, 71; drinks moderately beer. March 19, albumen, uric acid, blood, hyaline and waxy casts; March 26, albumen, uric acid, no blood, no casts; April 1, trace of albumen; April 20, urine normal. An examination two years later: urine normal.

Sixth.—Ch. L., saloonkeeper, 50; potator. April 6, albumen, hyaline and waxy casts; April 13, albumen, no casts. Went to Europe.

Seventh.—Mrs. L., 49; abstinent. February 7, albumen, hyaline and granular casts; February 15, albumen, no casts; February 22, albumen; February 29, albumen; March 10, albumen; March 20, albumen; April 9 to April 25, trace of albumen; May 18, normal.

Eighth.—Wm. B., cigarmaker, 63; drinks moderately beer. April 2, albumen, hyaline and granular casts; April 17, trace of albumen, no casts; May 15, normal.

Ninth.—G. R., physician, 72; is suffering from Bright's disease more than ten years. March 25, albumen 0.5 per cent., hyaline, granular and waxy casts; April 8, albumen, few hyaline casts;

April 22, albumen, no casts; June 7, 0.08 per cent. albumen. Discontinued potassium nitrate. June 20, 0.3 per cent. albumen, few hyaline casts. From June 21 took regular potassium nitrate. July 8, albumen 0.2 per cent.; July 15, albumen, 0.15 per cent. Took occasionally potassium nitrate up to September 15. September 15, albumen 0.15 per cent. Took regularly every two hours potassium nitrate. September 26, albumen 0.08 per cent.

Up to date patient takes potassium nitrate one to two times a day, and his urine is free from casts and albumen from 0.08 per cent. to 0.09 per cent.

Tenth.—S. K., artist, 68 years. December 13, hydrops of both legs and scrotum; urine—albumen, hyaline and granular casts.

R Prsnitz applications, changed every six hours.
Elevated position of legs. Potassium nitrate, 15 grains every two hours. Light diet; four milk punches with egg a day.

December 17, hydrops disappeared; patient can sit up in chair, with legs elevated; December 20, few hyaline casts, trace of albumen.

R Potassium nitrate, every two hours 15 grains.
Light diet; four milk punches with egg a day.

December 29, no casts, no albumen, patient can walk about; January 3, urine normal, potassium nitrate 15 grains three times a day; January 10, urine normal, potassium nitrate 15 grains three times a day; January 24, urine normal. Patient discharged.

Eleventh.—H. N., druggist, is suffering from Bright's disease over ten years. April 5, concentrated urine, granular casts, albumen 0.7 per cent.

R Potassium nitrate 15 grains every two hours;
light diet.

April 10, albumen 0.15 per cent; April 17, few granular casts; May 25, few granular casts, albumen 0.1 per cent. The same treatment.

The dose of potassium nitrate is 0.5 to 1.0 dissolved in 20.0 aqua every two hours till the casts disappear and the albumen is reduced to a trace, then the same dose three times a day and several weeks after the urine is normal. Potassium nitrate does not disturb the stomach or the intestines, and has no bad effect on the patient. It acts in some cases constipating, and this action has to be neutralized by a natural aperient water taken every morning.

If hydrops is present, I found the most successful treatment "Prsnitz applications," with elevation of the legs over the level of the pelvis.

The diet: Mostly vegetable and farinaceous food, meat sparingly once a day, buttermilk, milk, milk and egg, with or without liquor.

Under Bright's disease I comprehend chronic and acute nephritis with presence of albumen and casts in the urine.

I will not claim that the disease is curable in the last stages, but I am convinced that it is possible to stay the disease and prolong life.

In cases 1, 3, 5, 7, 8 and 10 was hydrops present.

Case 9 is of ten years' duration. The action of the remedy is made very clear in this case. Till June 7 the albumen was reduced to 0.08 per cent. In the two following weeks the remedy was not taken and the albumen increased to 0.3 per cent., with the reappearance of hyaline casts. In the next three weeks of treatment it went down to 0.15 per cent., and the casts had disappeared. Up to September 15 the patient took occasionally the remedy and the albumen did not increase. Then the patient took potassium nitrate regularly every two hours, and September 20th the albumen was down to 0.08 per cent.

I had intended to collect more material before publishing my experiences, but on second thought in consideration that the death rate of Bright's is the highest next to tuberculosis, it being 75 per cent. of the latter, I would consider it a crime against humanity to delay the publication any longer.

RECORD OF A FRENCH CASE OF FEMINE SEXUAL INVERSION.

By Douglas C. McMurtrie,

New York.

THE study of the phenomenon of sexual inversion as manifested by women is still too young to justify any very didactic conclusions. The most valuable material bearing on some of the problems involved which can be presented consists of accurate and reliable case reports of which there have been far too few recorded.

With the belief that an accurate report of this kind will be found more interesting and more illuminating than generalizations, I venture to present a translation of an unusually instructive case record.

The observers, Dupony and Delmas, report as follows:

"When one speaks of homosexuality one thinks almost always of masculine amours. But uranism is far from being an attribute of the male sex only; on the contrary, feminine inversion is quite as frequent as masculine. It is, however, more easily concealed, but, on the other hand, it finds means for its satisfaction with greater difficulty, often hesitating to break through the restraints

of social conventions and innate modesty. Some conspicuous examples, however, bear witness that this is not always the case.

"We wish to report today, following out the observation of a case of masculine inversion presented at the preceding session, on two cases of feminine inversion, and we shall endeavor in presenting them to show the constitutional character of this perversion as it is regarded by Magna, Garnier and Arnaud.

"Jeanne M., dressmaker, twenty-four years old, came to the clinic on October 20, 1904, with the following record registered by Dr. Legras: 'Melancholic delirium, based on mental debility. Auditory hallucinations. *Blesité* imaginary fears. Partial mutism. Says that she is persecuted by everyone; that her mother wishes to kill her and throw vitriol at her. Voices speak to her of death, etc. She came to the *commissariat de police*, declaring that there had been stolen from her a savings-bank book, and making incoherent remarks.'

"Neither her ravings nor her hallucinations interest us; we wish to speak only of her homosexual tendencies. She made to us in effect an avowal of a passion which she entertained for her patroness. She loved her in a most extravagant fashion, to the point of not being able to work when she saw or heard her in the workroom. She would be obliged to stop her work to admire in silence.

"She presented her infatuation to us as a spiritual affection, psychic only, and erotomaniac in consequence, affirming that she experienced no sexual sensations regarding her patroness. 'The love for me,' she declared, 'is not physical love; it is admiration. It is not sensual love; it is mystic love. It is her appearance which pleases me. I would never have thought of sleeping with her. I would have been ashamed of that * * *'

"Nevertheless, when pressed by precise questions, making her enter into the details of her history, it was possible to discover the sexual attraction and the physical desire.

"She was jealous of the husband of her patroness, and informed herself, according to her comrades in the workroom, regarding the intimacy existing between a married couple. One of the girls having said to her one day, 'that the patroness did not love her husband and no longer had relations with him,' she felt much relieved from the painful thought which had been torturing her, and she took infinite joy in this item of information. She would have been glad if conjugal intercourse had never taken place and would have gladly imagined this and persuaded herself of this belief had not a daughter, alas, been born of the marriage, thus proving beyond refute the existence of such relations.

"Her love was so violent that she was brought completely under the control of her beloved. She submitted in a docile manner to her least caprices, she obeyed her blindly whatever she might be ordered to do. 'This woman,' she told us, 'makes me do whatever she wishes. If she asked it of me, I would steal, I would

undertake violence, I would commit suicide, on condition that she might be with me."

"She had not dared to declare these sentiments to her patroness, but the silent sorrow of her love was poured out in stifled cries, in ardent letters laboriously written and never sent. This was the substance of them: 'Madame, I love you with an unspeakable love, I am capable of all madness to please you, etc.'

"Her modesty finally permitted one last confidence. She would have been gladly willing 'to go' with her if she (the patroness) had proposed this to her. She would have been glad to give her pleasure. Personally, however, she was content 'to contemplate.'

"In our opinion, Jeanne M. is a decided invert, a constitutional uranist; and her inversion is not purely platonic, erotomaniac in some way, that is to say, accompanied by a sexual anesthesia; but, on the contrary, frankly sexual and endowed with a taste for the voluptuous act. Not only does she feel herself attracted towards another woman, from whom she would wittingly accept voluptuous caresses, but she also entertains a vigorous repugnance to heterosexual relations. Men did not please her, she said, and never had she consented to the intimacy of a man; intimacy she would gladly permit to a woman, even a woman other than her patroness.

"The passion described has not been, however, her only love affair. Jeanne M., before her patroness, had loved other women in the same manner; her last love is only, she assures us, the most ardent and engrossing. To be accurate, therefore, it is not a woman—an individual—whom she loves, but woman in general, her entire sex.

"Jeanne M., on the other hand, an onanist since the age of sixteen, is a virgin. She had never experienced, according to her statement, other than solitary practices; she had never submitted to relations with others. Her original timidity, her inherent modesty—the decrement of which even she herself had earnestly desired—had never been actually broken down, and it is this which explains the restraint of her senses, the apparent absence of physical desire, and the concept of an ideal love, mystic and exclusively theoretical. Had one experience thrown her into the arms of a lesbian, it is certain she would have enjoyed the voluptuousness of their embraces. The attraction of servitude to her patroness, the desire of obeying her meekly, the need of feeling dominated by her—all these appear to us as sexual characteristics of her love."

The authors comment that the subject of this case was evidently a simple invert.

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BALTIMORE, JULY, 1914

MALE STERILITY.

THE time has come when in childless marriage the finger of suspicion should not always point to the woman. To be sure, she is often the offender, but in the event of no child she is not always the party at fault. So in pointing the condemning finger, one should be wary as to the party accused. This not only applies to the husband, but also the physician, as well as friends of the couple. It is only in justice to the female that the physician at any rate should subject the husband to a thorough examination before the woman is compelled to submit to dilatation and the curet. Writing along these lines, Barney, in the *Boston Medical and Surgical Journal*, discusses some of the causes of sterility in the male. He states: There are no very accurate figures as to the frequency of childless marriages. According to Huhner, 10 per cent. of all unions in New York are without issue. But here one must not forget clandestine but admittedly widespread methods used for the prevention of conception before accepting the above-mentioned statistics as absolutely accurate. Therefore the only material on which we can work are those instances in which childless couples come to the physician for relief, and here figures vary as to the proportion in which the husband is at fault. According to the various authorities the husband is at fault from 1 to 80 per cent. of instances. Huhner, in 192 cases from various authors, found the husband responsible in 17 per cent. In view of these facts, the investigation of childlessness should begin with the microscopic examination of the husband's semen, not with a curettage of the wife. In a series of 37 cases which actually underwent operative interference for the relief of sterility in a large New York hospital, some despite negative pelvic findings, at the end of a year only two became pregnant. It was

only possible to examine four of the husbands of the women in this group. Two were found normal, and in the semen of the other two there were no spermatozoa, and an examination of the genitalia showed evidence of an old gonorrhoea. Bearing these facts in mind, the author of the above article, through the co-operation of several gynecologists, was able to examine the husbands in forty childless marriages. Of these twenty were actually sterile. Yet the wives of four of these had had more or less severe operations done upon them before it occurred to the operator that the husband possibly was at fault. With these facts in hand, should we not be more careful where we put the blame? It teaches, however, a great lesson—namely, before subjecting the wife to operative interference when seeking relief for sterility, first demand that the husband be subjected to a thorough examination by a competent man. As to the causes of sterility in man there are many, such as undescended testicle in some instances, and those rare malformations, epispadias, hypospadias, exstrophy of the bladder, in any of which, though the spermatogenic function may be active, yet owing to the nature of the disability impregnation of the female impossible. Occasionally non-venereal diseases may attack the testicle and produce sterility, foremost among which is mumps. Syphilitic orchitis is another prolific cause of sterility in the male. Abscess of the testicle, likewise tuberculosis, is occasionally followed by azoospermia. Another source of sterility is repeated and prolonged exposure to the Roentgen ray. Though the above mentioned, together with other causes, are the occasional producers of sterility, away and above the most frequent in the male is gonorrheal epididymitis. In summing up his experience, Barney draws the following conclusions:

1. The cause of sterility in man is due to venereal disease, generally gonorrhoea, in the vast majority of cases.
2. Oligospermia or azoospermia may occur without obvious cause.
3. A single examination of the semen is insufficient.
4. Marriages may continue to be sterile, even with the finding of active spermatozoa in the husband, and a normal genital tract in the wife.
5. It is noteworthy that in no case of male sterility regardless of the cause is masculinity in the least impaired.

Medical Items.

DR. G. MILTON LINTHICUM, Physicians and Surgeons, 1893, and Mrs. Linthicum have closed their town residence, 817 Park avenue, and opened their home at Lyncrest, Linthicum Heights.

THE maternity ward of the Hebrew Hospital will be built by John Hiltz & Sons Co. at a cost of \$54,300, and will be turned over to the hospital by December 6. It will be one of the most complete in the city, and is the gift of Abraham Mendels in memory of two of his brothers.

DR. HENRY E. AUSTIN of the New Jersey State Hospital for the Insane, at Trenton, has been appointed physician-in-chief of the hospital for the insane at Bayview.

Dr. Kenneth B. Jones, who has been the physician-in-chief at the hospital for some time, has accepted a position at Rosewood Home for the Feeble-Minded, Owings Mills.

Dr. William Eichelberger, who has been at Bayview for some time, becomes resident physician at the hospital for the insane. His assistant will be Dr. Joseph Lipsky of Baltimore, and a recent graduate of the College of Physicians and Surgeons.

DR. A. LEE HICHEW has been appointed medical supervisor of the Franklin Square Hospital, Baltimore, to succeed Dr. G. S. LaWall.

DR. FRANK MARTIN, 1000 Cathedral street, sailed from New York June 13 for Europe on board the steamer Oceanic, to be absent until August. Dr. Martin will attend the tri-centennial celebration of the University of Groningen, in Holland, at which he will represent the University of Maryland.

DR. AND MRS. F. H. BAETJER of Catonsville sailed recently from New York on the steamship Kaiser Wilhelm II for Bremen, and will spend the summer traveling abroad.

THE Police Board of Baltimore reappointed the Board of Medical Examiners, which consists of Dr. James M. Craighill, chief police physician, and Drs. Hubert C. Knapp, Thomas P. McCormick, Walter F. Sowers and Elliott H. Hutchins.

THE twenty-fifth anniversary of the opening of the Johns Hopkins Hospital, Baltimore, will be celebrated with appropriate exercises the first week in October. The preliminary program provides for addresses and papers by

a number of well-known teachers and clinicians, also by graduates of the Johns Hopkins Medical School.

DR. ADOLPH MEYER, director of the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, has been appointed a member of the board of managers of the Maryland Training School for Girls.

DR. PHILIP BRISCOE, Mutual, Md., has been elected president of the State Board of Aids and Charities. The board has named a committee to study the question of co-operative purchasing by the institutions which receive State aid, of which Dr. J. H. Mason Knox is a member.

DR. NATHAN R. GORTER, Commissioner of Health for Baltimore City, has appointed Dr. Alexander J. Gillis assistant superintendent of Sydenham Hospital, to succeed Dr. Walter W. Point, Jr., Baltimore.

A FAREWELL dinner was given recently at the University Club to Dr. R. Martin Bruns, who left Baltimore June 1 to take up the practice of medicine in Indianapolis. Many of the friends of Dr. Bruns were present to wish him good luck. Dr. Bruns is a graduate of the Johns Hopkins Medical School, class of 1902, and resided at 1401 Park avenue.

DR. GUSTAV H. WOLTERECK has been appointed throat inspector in place of Dr. Wilbur P. Stubbs, recently named as a medical examiner of schools.

DR. RALPH R. BROWNING, Myersville, Md., has been elected health officer of Frederick county, vice Dr. James M. Goodman of Frederick.

DR. JOHN MCFARLAND BERGLAND, Johns Hopkins Medical School, '04, and Mrs. Bergland will close their town residence on Biddle street in July and leave for Biddleford Pool, Me., where they will spend the remainder of the summer.

MISS GRACE ELMA UHLER, daughter of the late Dr. John R. Uhler, of 1615 McCulloh street, Baltimore, desires to announce that she is prepared to take notes or translate from Greek and German books, pamphlets, etc., into English, and would appreciate work from the physicians.

AT the annual meeting of the Medical and Chirurgial Faculty the following officers were elected: President, Dr. James W. Humrichouse, Hagerstown; vice-presidents, Drs.

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THE Phipps Psychiatric Clinic of the Johns Hopkins Hospital has engaged two graduates of the Pennsylvania Orthopedic Institute, Philadelphia, for their mechanical and hydratic departments—Miss Katherine Hoffiman, formerly of Walla Walla, Wash., a graduate of the Ensworth Hospital, St. Joseph, Mo., and Mr. Jeremiah T. Minahan of Philadelphia, Pa.

PLANS for a building for measles at Sydenham have been laid before the Board of Awards. The plans call for a one-story structure with provision for fifteen to twenty patients, the cost to be about \$25,000. The new building and edifices now standing at Sydenham can be made to fit into the scheme for a general hospital to be provided out of the \$750,000 loan authorized by the recent Legislature. There are about 12 acres of land at Sydenham, and this is declared to be sufficient for a large hospital such as it is proposed to establish.

DR. JOHN HOWLAND sailed recently from New York for Bremen.

BIRTHS.

To Walter H. Mayhew, M.D., University of Maryland, '01, and Mrs. Mayhew, June 3, 1914, a daughter, Matilda Ruth Mayhew. Dr. Mayhew is a resident physician at the State Sanatorium, Sabillasville, Md.

To George C. Lockard, M.D., University of Maryland, '03, and Mrs. Lockard of 1631 W. Lafayette avenue, in May, 1914, a son. Dr. Lockard is associate professor of clinical medicine and pediatrics at the University of Maryland Medical School.

MARRIAGES.

H. CLIFFORD GRANT, M.D., University of Maryland, '14, of North Carolina, to Miss Nora

J. Mee of Baltimore, Md., at Baltimore, June 1, 1914. Dr. Grant will take his bride to North Carolina.

J. C. POUND, M.D., Baltimore Medical College, '06, to Miss Bertha M. Costello, both of Baltimore, at Baltimore, June 1, 1914. Immediately after the ceremony Dr. and Mrs. Pound left on an extended automobile tour.

DEATHS.

WILLIAM M. S. CURTISS, M.D., Baltimore University, 1893; a member of the Connecticut State Medical Society; in 1900 a representative from Cornwall in the General Assembly, died at his home in Bristol, Conn., May 17, 1914, from nephritis, complicated by pleurisy, aged 43 years.

JOHN A. BROBST, M.D., College of Physicians and Surgeons, Baltimore, 1885, secretary to Secretary of the Navy Thompson at the time of the settlement of the Nova Scotia fisheries claim, died at his home in Allentown, Pa., May 4, 1914, from septicemia, aged 61 years.

WILLIAM H. MINNICH, M.D., College of Physicians and Surgeons, Baltimore, 1890; a member of the Medical Society of the State of Pennsylvania, and for eight years jail physician of York county, died at his home in Dallastown, Pa., May 1, 1914, aged 49 years.

ROBERT R. NORRIS, M.D., University of Maryland, '78, of Parkton, Md., died at his home May 23, 1914, aged 63 years.

CLAUDE A. STONCIPHER, M.D., Baltimore Medical College, '04, formerly of 1655 North Fulton avenue, Baltimore, died from Bright's disease, May 30, 1914, aged 34 years.

RICHARD PINKNEY BLACKSTONE, M.D., University of Maryland, '49, of River Springs, Md., died at his home May 12, 1914, aged 91 years.

DAVID WILLIAM BULLUCK, M.D., University of Maryland Medical School, '73, of 309 N. 4th street, Wilmington, N. C., died at his home May 7, 1914, aged 61 years. Dr. Bulluck was the founder of the Catherine Kennedy Dispensary and Rest, and was one of the organizers of the Associated Charities of Wilmington. He was for many years visiting surgeon to the Atlantic Coast Line, and was one of the organizers and a past president of the Association of Surgeons of the Atlantic Coast Line.

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Abstracts.

FURTHER OBSERVATION ON PRURITUS ANI: ITS PROBABLE ETIOLOGIC FACTOR; RESULTS OF TREATMENT.

By Deight H. Murray, M.D., Syracuse, N. Y.

Read before American Practologic Society, June 16-17, 1913.

DR. MURRAY'S paper, which is a continuation of his investigations on the etiology and treatment of pruritus ani, gave some new points which he had observed during the past year, and his additional experience in the treatment of patients. He found no reason for materially modifying his former reports, but has gathered data which helped to prove the correctness of his previous work. He found streptococcic infection in three cases of pruritus ani and vulva, and in four cases of pruritus that had involved the scrotum as well as the anus. These complicated cases improved, with the exception of two vulva cases, by the use of the vaccine treatment.

During the past year Dr. Murray has increased his former series of 32 cases by 25 additional cases, in five of which streptococcic infection was not found. These cases showed other infections, which still further proves the coccigenous nature of pruritus ani, and also demonstrates that other bacteria than streptococci may bear a casual relationship, as was hinted in his first paper on this subject.

His cases, so far as he has been able to determine, have not been affected by diet. Since Dr. Murray discovered the infection in pruritus ani he has never interfered with the food of any patient; neither has he restricted them in the smoking or drinking habit. The improvement under the vaccine treatment, without regard to eating, drinking or smoking, gives him additional proof for the bacterial theory.

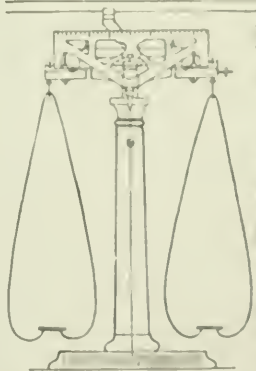
During the past year he has carefully investigated as to whether or not the itching extends into the anal canal beyond Hilton's white line, with the result that only in one instance did it extend beyond that point, and then only for a short distance.

His investigations of the past year have given him additional proof that pruritus ani is not caused by any local lesion within the anal canal, and that when such lesions exist with pruritus ani they are coincidental.

In the cases that have been operated for local lesions the pruritus ani has not been permanently improved as a result of the operative procedure.

He said that rectal and general surgeons have observed many cases of fistulae with discharges upon the anal skin, without pruritus ani being present. The same is true of hemorrhoids, constipation and other rectal lesions, pruritus ani occurring in only a small proportion of such cases. He, therefore, still holds that when pruritus ani exists in connection with other lesions that it is a coincidence. In his 1912 report he gave a summary of 900 consecutive rectal cases wherein this fact was established fairly well.

He referred to the opsonic index, or, more properly, the coeffi-



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cient of extinction of opsonins, and claimed that much valuable information was to be gained by this test.

His work shows that if a complicating infection exists, and other bacteria than streptococci are found to be the sole invading organisms, we must use the corresponding autogenous vaccine. The opsonic index, following a bacterial diagnosis, is the proper method for determining this.

The results of treatment and the history of patients prove to him that if pruritus ani exists with local lesions which demand operation, that the prognosis depends upon whether a skin infection is present or not. If the skin infection is present, the local lesions may be cured by the operation, but the patient should not be led to believe that the pruritus ani will also be cured by it. Per contra, if a skin infection does not exist with a local lesion and itching, the prognosis may be that the itching will very likely cease with the cure of the local lesion.

After personal investigation in treating, watching results, noting how cause, effect and results dovetail together; comparing these investigations with statements and theories made in text-books, and in articles appearing from time to time in medical journals, and containing no definite pathology or scientific reasons for cause and effect, Murray cannot understand how the profession will uphold such theories, rather than the bacterial theory which has been so well proved in his own cases and confirmed by other observers.

The uniformity of the bacteriologic findings is a strong support for the bacterial theory of the etiology of pruritus ani. The chronicity of all the cases, the uniform symptoms, the similar conditions of the skin, the locality, the regularity as to the time of attacks, the uniformity of itching outside of Hilton's white line, the uniform blood findings as the coefficient of extinction of opsonius, and the fact that all local applications which have given beneficial results in the past have contained a strong germicide, all point directly to a common cause. Further confirmation is found in the uniformly good results of treatment with autogenous vaccine of the variety of bacteria against which the patient has a low phagocytic power, and in the lack of good results by the various haphazard methods of treatment in general vogue.

His reference to fissures in previous papers having been misunderstood by some, he desired to state that he had referred only to fissure-like cracks of the skin, and not to anal fissures or ulcers.

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Dr. Murray refers to a paper written by Dr. Jerome Wagner of New York city, published in the May number of the *Medical Review of Reviews*, in which Dr. Wagner reports some erroneous ideas claimed to have been gleaned from reading Murray's first two reports. Dr. Wagner, not having been able to confirm these reports, Dr. Murray pointed out the errors of technique in Dr. Wagner's work, as well as his errors in the interpretation of the reports.

Dr. Murray gave statistics in favor of his theory drawn from three years' original work on the subject; he also gave a summary of the results of treatment, showing the favorable clinical

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results with autogenous vaccines in a large majority of the cases treated.

He summed up his conclusions as follows:

(1) Results of the past year's work continue to uphold the correctness of the bacterial theory of pruritus ani.

(2) It is advisable to make a bacteriologic examination of all cases of pruritus vulva; also of cases of scrotal pruritus.

(3) The co-efficient of extinction of opsonins is a valuable aid in diagnosis in complicated and obstinate cases.

(4) Pruritus ani in this series of cases rarely extends above the white line of Hilton, and it is still subjudice.

(5) The presence of a skin infection with a local lesion begets an unfavorable prognosis for the cure of pruritus ani by an operative procedure.

(6) The absence of a demonstrable skin infection and the presence of the local lesion, with pruritus ani, will justify us in making a favorable prognosis for the cure of the pruritus ani by an operative procedure.

(7) Pruritus ani, with such infection as we have demonstrated, and a lesion existing in the anus or rectum, according to his statistics, is a coincidence; and the latter lesion is not the cause of the pruritus ani.

(8) The sphincter muscle does not allow a leakage of rectal mucus upon the anal skin of one who has pruritus ani, except there is a patulous anus, any more than it does a normal individual who has no pruritus ani. The moisture of the parts is due to a low grade inflammation of the infected anal skin.

RESULTS IN A SERIES OF CASES OF TONSILLECTOMY AT THE MASSACHUSETTS GENERAL HOSPITAL, THREE TO FOUR YEARS AFTER OPERATION.

Dr. J. Payson Clark, Boston.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

POSTALS were sent out in July, 1912, to patients who had been operated on in 1908, and 143 patients responded by presenting themselves to the clinic in person, where they were subjected to an examination, and answered a set of questions with reference to the operation and after-effects. From these results the following summary is presented: The patients, with a few exceptions, were under 15 years of age at the time of the operation. Hemorrhage after tonsillectomy calling for special treatment was of rare occurrence. The condition for which the tonsils were removed was relieved in nearly every case, even in those in which there was some tonsillar tissue remaining. An improvement of the general health was to be expected after tonsillectomy done for such cause. Children who had had tonsillectomy certainly showed no increased tendency to illness, and were probably less susceptible than before the operation. The present health of these children is excellent in the majority of cases. What is apparently tonsil tissue is found much more often than supposed after tonsillectomy. The soft palate was symmetrical, and the faucial pillars and tonsil fossae normal in a great majority of the

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cases. The accidental cutting off of the uvula in four cases caused no bad symptoms. Most of the cases of sore throat and tonsillitis were relieved by the operation. In many cases in which there appeared to be tonsil tissue remaining the patients were in perfect health, and in others in which there were symptoms those were undoubtedly due in many cases to causes other than the tonsil remnants. The ordinary voice or speech may be said to be practically unaffected by tonsillectomy. No investigation was made of the singing voice. In most of the cases in which enlarged cervical glands could be felt there was tonsil tissue on the same side. In nearly half the cases in which there was tonsil tissue present there were no enlarged glands. Carious teeth were apparently a direct cause of some cases of cervical adenitis.

THYROTOMY FOR CANCER OF THE LARYNX, WITH REPORT OF ELEVEN CASES.

Dr. D. Crosby Greene, Boston.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

IN a paper presented to this association in 1906 we reported the results of an investigation of the lymphatic drainage of the larynx by means of submucous injections of methylen blue and mercury. The results obtained are confirmatory of those reported by others in showing that the network of lymphatic vessels which extends beneath the mucous membrane throughout the interior of the larynx is richer in the number and size of the vessels in the supraglottic region, relatively poorer in the subglottic portion, while on the vocal cords the vessels are very small and widely separated. These anatomic facts account for the slow growth and late development of the disease in the cervical lymph nodes in cases of epithelioma of the cords, and furnish an argument for the possibility of cure in early cases by the operation of thyrotomy and excision of the growth with a wide margin of healthy tissue. This is supported by the result of the operation in the hands of numerous operators, both in this country and abroad, so that at the present time it is almost universally recognized as the proper procedure for the treatment of early intrinsic cancer of the larynx. Certain details of the technic have an important bearing on the immediate and after-results of the operation. The steps of the operation are: 1. Ether by inhalation, preceded an hour before by $\frac{1}{4}$ grain of morphin and 1/150 grain of atropin. 2. With the head slightly extended a median incision is made, extending from the lower border of the hyoid bone to the lower border of the cricoid cartilage. This incision is carried down through the prethyroid muscles until the thyroid and cricoid cartilages and cricothyroid membrané have been definitely exposed. 3. A 1 per cent. solution of cocain is injected through the cricothyroid membrane into the cavity of the larynx. 4. The patient is now placed in the Trendelenberg position, and a thick pad placed under the shoulders to bring the larynx into prominence. 5. The cricothyroid membrane is next incised in the median line, and through this incision a swab of 10 per cent. solution of cocain is introduced and applied to the laryngeal mu-

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cous membrane. 6. The xyphoid cartilage, after a pause of five minutes, is divided from below upwards. In young subjects this may be done with a knife, but in the majority of cases where the cartilage has become ossified, it is best to use strong curved scissors with dull points. 7. The thyroid wings are now widely retracted, and an examination of the growth made under good illumination. 8. Beginning at the free margin of the thyroid cartilage, on the affected side in front of the growth, the internal perichondrium is elevated from off the cartilage with a sharp elevator from before backwards to a line well behind the limits of the growth, as well as above and below it. All the soft structures are thus freed from the underlying cartilage. 9. Parallel horizontal incisions are now made with scissors above and below the growth. These incisions are carried about one-half inch back of the posterior limit of the growth. 10. The growth, with its surrounding tissue, is now entirely removed with a wire snare by which the posterior attachments are severed. Much depends on the proper selection of cases. When the growth is so extensive, even though confined within the cavity of the larynx, that the larynx cannot be opened without cutting into the growth, recurrence is not only possible, but probable.

CONGENITAL OCCLUSION OF THE POSTNASAL ORIFICES, WITH REPORT OF A CASE.

Dr. Charles W. Richardson, Boston.

Paper read at the Thirty-fifth Annual Congress of American Laryngological Association, held May 5, 6 and 7, 1913, in Washington, D. C.

IN July, 1912, a case came under my observation in which there was complete osseous obstruction of the postnasal orifices at as early a period in the life history of the patient as any observer has noted such a condition. In a search of the literature I have found only a few cases in which the obstruction was observed in infancy. While it is not possible to tabulate all the cases recorded in the literature, I judge that they do not exceed 100. The obstruction of the postnasal orifice may be membranous or osseous. The former are usually found posterior to the nasal cavities in the nasopharyngeal cavity, but lie in contact with the postnasal orifices so as to completely obstruct them, while the latter are usually placed within the chamber within a millimeter or more from the free border of the posterior nasal orifice. To these two forms may be added congenital atresias, by which the bones entering into the formation of the postnasal orifice become united, thus more or less completely obstructing the postnasal orifices.

The child that came under my observation in July, 1912, had marked difficulty in breathing. The child struggled for air, and the face became suffused and slightly cyanosed, the condition being relieved when the child began to cry. Whenever it ceased to cry there would be a recurrence of the difficult breathing. Examination demonstrated without doubt a deformity which was a complete obstruction of the postnasal orifices. By the end of the second week the child learned to maintain mouth breathing, and also learned to feed in a short time, and has developed in a normal manner. The question is: When is the proper time to operate? The marked success with this case seemed to favor the expectant surgical policy in these cases.



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Prepare the Babies for Hot Weather.

DURING the month of June it is not a bad plan for the physician to take mental "stock" of the babies under his care, especially such as are bottle-fed, with the general idea of recommending such treatment as will tone up and vitalize those whose nutrition may be below par, so that they may enter the trying summer months in the best possible condition to ward off or withstand the depressing influences of extreme heat or the prostrating effects of the diarrheal disorders of the heated term.

Careful attention to feeding is, of course, a *sine qua non*, and the details of the infant's nourishment should be carefully investigated and regulated. But this is not all. Many bottle-fed babies are below standard from a hematologic standpoint. The marasmic anemic baby deserves special attention in the way of building up and restoring a circulating fluid which is deficient in red cells and hemoglobin. In the entire *Materia Medica* there can be found no direct hematic quite as suitable for infants and young children as Pepto-Mangan (Gude). In addition to its distinctly pleasant taste, this hemic tonic is entirely devoid of irritant properties and never disturbs the digestion of the most feeble infant. Being free from astringent action, it does not induce constipation. A few weeks' treatment with appropriate doses of Pepto-Mangan very frequently establishes suffi-

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A TEN-YEAR record of practical and highly satisfactory demonstration of Danha's Serum Therapy would afford us a fitting occasion to repeat in part the history of hay fever and its theories:

(1810)—Boston, an English physician, was the first to give a scientific and accurate description of the sickness. Linnaeus treated the ailment, whose periodic appearance he well recognized, to the first hint of spring or blushing sunshine, to mist or similar atmospheric influences, which struck the eye. Inasmuch, however, as these influences are not bounden to the definite expressed time of the hay fever, this explanation could not satisfy.

(1831)—Ehlersson accepted another moment as its solvent, crediting the pollen of certain plants as the excitant cause, obviously, to be sure, without founding same on actual proofs. Such were first brought to notice.

(1873)—by Blackley, who pointed out that certain pollen, thus from rye and other grasses, whose presence in the atmosphere at time of the hay fever was established, were capable, by penetrating the mucous membrane of the hay fever patient, to produce the typical symptoms.

This pollen theory, which today we have learned to be a correct one, was dropped by the soon-following development of bacteriology in favor, as first expressed by Helmholtz, of its bacterial cause.

Helmholtz, like other investigators, found in the mucosa of the patient vibrations and staphylococci which by their discoverers were accepted as the hay fever excitant, although, obviously, no subsequent tests to prove this perception by bringing the bacterial culture to the sensitive mucous membrane were made. Again, other authors saw the causal agent as due to the aromatic or other volatile emanations from plants during blossom time.

Each, for these contradictory, and by far, not adequately stated, perceptions, the work of Linnaeus, connected with Boerhaave, Kaimmiser, Wucherich, Jackson, Leffmann, Tallboys and others, brought some glow clearing.

(1894)—Ehlersson, according to various accounts during the preceding ten years, were positively placed and announced to the medical profession.

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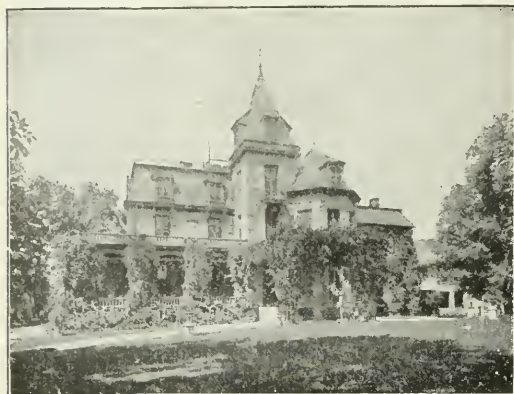
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